Family Psychoeducation

Implementation Resource Kit

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Implementation Tips for Public Mental Health Authorities

The Evidenced-Based Practices Project presents public mental health authorities with a unique opportunity to improve clinical services for adults with severe mental illness. Service system research has evolved to a point where it can identify a cluster of practices that demonstrate a consistent, positive impact on the lives of people who have experienced psychiatric symptoms. These practices include integrated dual disorders treatment, supported employment, illness management and recovery, assertive community treatment, medication management and approaches to psychiatry, and family psychoeducation. This document focuses on family psychoeducation**.**

What is Family Psychoeducation?

Family psychoeducation is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that practitioner, consumer, and family work together to support recovery. It almost always engenders hope in place of desperation and demoralization. There is abundant evidence for its effectiveness in working with consumers who experience schizophrenic disorders, but there is increasing research support, as well, for its use with mood disorders, OCD, borderline personality disorders, and even for consumers who lack family support altogether. Thus, those families and consumers with the most severe psychiatric disorders will experience the greatest benefit from FPE.

What is an Implementation Resource Kit?

Extensive research demonstrates that implementing family psychoeducation in routine mental health settings dramatically improves the lives of people with severe mental illness. To this end, a "implementation resource kit" has been designed to involve family members, consumers, mental health program leaders, and practitioners along with public mental health authorities in a consolidated effort to implement family psychoeducation into routine mental health settings. The goal is to support the recovery process of consumers by reducing symptoms, rehospitalizations, isolation, and unemployment.

Implementation resource kits include: a practitioner's workbook, a review of the scientific evidence for superior outcomes, web-based resources, separate information sheets for families, consumers and practitioners, introductory and skills training videotapes, suggestions for mental health program leaders and administrators, financing recommendations, and information about outcome measures and fidelity scales.

What is the role of the public mental health authority in implementing evidence-based practices?

One of the primary and essential roles of the public mental health authority (PMHA) is to serve as leader in bringing all the stakeholders together (consensus building) to firmly understand and articulate a vision of family psychoeducation and a plan for the implementation of family psychoeducation across a mental health system. This can be accomplished by using evidence to demonstrate that the quality of care improves with the implementation of this practice without significantly increasing costs. The public mental health authority plays a pivotal role in assuring buy-in from the stakeholder groups.

In summary, effective PMHAs

- Articulate a vision
- Bring stakeholders together (consensus building)
- Plan the implementation process
- Demonstrate cost-effectiveness

A key element is the PMHA's relationship with the implementing mental health agencies. Experience and some research suggests that the state's PMHA, mental health centers, and hospitals need to agree and commit to implementing new practices. This is may be a new role for these groups and different relationships may need to be formed. The best outcomes occur when:

- commissioners and mental health trade associations act in concert with clear definition of roles and responsibilities;

- the local agencies and/or their trade association take a clinical and programmatic lead;
- the PMHA encourages the initiative and provides key forms of support, including, financial, publicity and other incentives for agencies.

In some states, it is worth noting that present reimbursement systems reward state and federal budgets when Evidence Based Practices are provided, but the additional implementation costs are borne by the local providers. Directives that local providers implement EBPs without additional support or "profit-sharing" arrangements have tended to increase friction between the state and local levels and have not easily led to success in implementing Evidence Based Practices. Thus, PMHAs should work to assess cost savings to the mental health system and find ways to support provider agencies regarding implementation costs and financial incentives for using Evidence Based Practices such as FPE.

There are a variety of roles the PMHA can play

- disseminating information about family psychoeducation
- promoting the implementation of family psychoeducation
- working in, and developing, partnerships with mental health centers and trade associations, a key to success in adopting and implementing this approach
- providing financial and political support, including fiscal and programmatic incentives
- exploring profit-sharing to provide equity and incentives for implementing FPE services

Planning for the change

Beyond consensus building, the PMHA's role is planning for, and leading, the change so that the practice will be accepted and sustained. This planning may include such factors as financing incentives, rules changes, contracting processes, human resources development, and assessment of outcomes. Just as important is the consistent communication of the expectation that services will meet current best-practice standards and, thereby, realize the potential benefits for all stakeholders. Presentations and orientation sessions by national EBP clinical leaders have proven essential and quite cost-effective in educating and persuading key stakeholders to commit to implementation.

The challenge of how to sustain the practice needs to be addressed as part of the initial planning process. The PMHA has to develop strategies to address this issue and ensure that it gets attended to so the practice will continue to grow and develop. Finally, the PMHA will need to ensure that there is a system in place to collect data on the outcomes of the practice. This will help to identify systemic problems and help sustain the program.

What roles do families have?

PMHAs are generally aware that families can help create an optimal home and social environment for the individual with mental illness. Families should participate in decision-making about their loved one's future life and living situation. Families are playing new roles in public mental health and are willing to work with mental health authorities. For family psychoeducation to be successful and sustained, it is important that the mental health authority include families as an important stakeholder group in planning the implementation of a family psychoeducation program.

How can family psychoeducation be funded?

Funding mechanisms may vary from agency to agency and state to state. For the most part, funds are used from the state Division of Mental Health and Medicaid. State leaders from the agencies work out a mechanism on how to pool monies that can be used to reimburse the services of family psychoeducation programs. In some cases Medicaid rules and codes have been rewritten to allow reimbursement for family psychoeducation. One state has adopted a case-rate approach, which fits well with implementation and promotes use of the modality (details available on request). In some states, Medicaid authorities support funding for family psychoeducation because there is such a large reduction in emergency room visits and hospital admission costs.

Who supports family psychoeducation?

There are several sources of support to help implement and sustain family psychoeducation. For example, constituency groups that can serve as allies to help change the system include:

- Family advocacy organizations such as the National Alliance for the Mentally Ill (state and local chapters) and state mental health associations have long recognized that education and support programs are beneficial for families coping with mental illness. Reports show that families who have participated in the family psychoeducation programs often become strong advocates. They may be more willing to financially support and advocate for the general operations of the community mental health service system. They may also get involved on planning committees, advisory boards or in political activities to support mental health programs and funding.
- The Agency for Health Care Policy and Research supported an extensive review of the scientific literature on the outcomes of family psychoeducation. The Patient Outcomes Research Team's (PORT) findings were that FPE greatly reduces relapse, rehospitalization, and improves community functioning. Subsequent studies and reviews have concluded the same. Recently, family psychoeducation in multifamily groups has been found to reduce negative symptoms (the control group's symptoms increased) and medical care use and medical illness among the participating relatives.

- The American Psychiatric Association practice guidelines recommend family psychoeducation as a first line or indicated treatment for schizophrenic and bipolar disorders. (For more information, see the "clinical measures" section of their website at www.psych.org.)

What are the benefits of Family Psychoeducation?

Evidence shows that for consumers whose families participate in family psychoeducation programs, relapse rates and re-hospitalizations decrease significantly within the first year after hospitalization when compared to consumers who only use medication with, or without psychotherapy. With a family psychoeducation program in place there is evidence of savings in all areas that traditionally accompany relapse, including hospital costs and the need for police interventions and crisis intervention. Employment rates for consumers usually double; in combination with supported employment, they can quadruple. Because it reduces medical care needs for both consumers and their family members, it can reduce overall health care costs. Successful outcomes improve stakeholder support for the mental health authority, helping to sustain the program.

Outcome results are critical for demonstrating to the effectiveness of the program to funding sources and for persuading more agencies to participate. It is also important to point out to the specific stakeholders what they may expect as benefits from practice of family psychoeducation and to determine, with the stakeholders, if these benefits are supported by outcomes in local practice. These benefits have occurred across many cultural and racial groups, throughout the United States and in several international studies and programs. For example,

For consumers

- Helps build a support network for recovery
- Provides hope
- Reduces relapse and hospitalization
- Improves symptom management
- Reduces medication dosages
- Improves social skills and community participation
- Increases employment, earnings and career options
- Strengthens family ties
- Reduces family conflicts

For families

- Provides hope
- Provides skills to support recovery
- Improves understanding of the illness
- Improves coping skills
- Reduces medical illness and medical care utilization
- Reduces feelings of stigma and isolation
- Reduces stress
- Improves family relationships

For practitioners

- Improves consumer outcomes, community functioning, and satisfaction for consumers
- Enhances understanding of severe mental illness and how to treat it
- Helps to achieve higher rates of recovery for consumers
- Reduces the need for crisis intervention over time
- Improves relationships with families and consumers

For mental health agencies

- Savings in emergency room and hospitalization costs
- Reduces need for crisis intervention and agency disruption
- Improves staff morale and commitment to this population
- Multifamily groups serve general case management and other purposes
- Enhanced reputation and fewer complaints and conflicts with advocates
- Improves cost-benefit ratio
- Builds a network of allies for community mental health, especially with family advocacy groups

What are the costs of not using the FPE?

The excess cost associated with not using FPE may include:

- the continuation of a high relapse rate;
- unnecessary hospitalizations;

- frequent crises that must be managed by outpatient, emergency or crisis program staff;
- unnecessary deterioration of functioning;
- higher rates of unemployment for consumers;
- alienation and sometimes political action by families and family advocacy groups.

By contrast, in a statewide study in New York, during the second year of treatment, found that for every $1 in costs for FPE in multifamily groups, there was a $34 savings in hospital costs. In a typical hospital in Maine, there was an average net savings of $4,300 per patient, per year over two years. The minimum reduction in hospitalizations has been about 50%, with some studies achieving up to 75% reductions over time. Ratios of $1 spent for this service to $10 in saved hospitalization costs can be routinely achieved.

Will FPE work in this mental health system and with many different cultures?

FPE was specifically designed for use in publicly funded community mental health services. For instance, the multifamily group version of FPE was developed in the South Bronx under adverse circumstances in a multicultural context. It has been refined to be cost-effective in routine mental health settings in many types of communities. Similar results have been reported in the Watts section of Los Angeles, Pittsburgh, six different cities in New York State, a wealthy suburban county in New Jersey, throughout the state of Illinois and the entire state of Maine, in Spokane, Washington, and in the borough of Harlem in New York City. Services are being provided successfully in nine cities in Scandinavia, to the Asian immigrant community in Melbourne, Australia, to thousands of families in China and in Hungary. It seems unlikely that there is any particular clinical or population group for whom this approach cannot be provided with the same kinds of results, except where there are large numbers of people who have no family or friends who are able to participate (e.g., some parts of Manhattan).

Does FPE require new resources or can resources be reallocated?

In mental health systems in which some psychosocial or psychotherapy services are provided, family psychoeducation can be provided largely by reallocation of services. If multifamily groups are established, total service effort will actually decrease in absolute terms. In systems in which the only service provided is brief medication visits on an infrequent basis, new service effort will have to be provided. However, a recent cost-effectiveness study shows that the extra effort will be more than recouped in saved intensive treatment costs, leading to no net increase in staff time or effort. Some special arrangements may be needed to provide access to families from some cultural groups. For some families, the program may need to use the services of a tele-interpreter service or its counterparts.

With respect to staffing, this approach is designed to largely replace individual meetings with consumers. Usually additional staffing will not be required until the program involves a very high proportion of the agency's consumers who are appropriate for the intervention. Most licensed mental health practitioners can learn to work within this model quite effectively. That includes social workers, psychiatric nurses, psychiatrists, psychologists, occupational therapists, and case managers.

What do consumers and families think of FPE?

The best answer lies in participation rates. In a major research demonstration project in six cities in New York State, providing services in both single- and multifamily formats, the drop out rate amongst very ill consumers from state and city hospitals was about 25% after two years. Most of the multi-family groups kept meeting for years afterwards. The major political problem faced by that project was that after several months of providing services, there were often complaints from families and consumers that more families were *not* being offered this service. Many mental health agencies that have offered these services for a period of time find that practitioners, consumers and families do not want them to end. However, the common challenge is finding the ongoing support very useful in improving the consumers' functioning and community participation.

How can FPE be implemented successfully?

Creating a positive environment in a mental health system for the implementation of FPE by mental health agencies is a critical role of the PMHA. Family psychoeducation usually takes place in community mental health centers. Frequently, the work begins while the individual consumer is hospitalized and continues after discharge to outpatient services. People from a variety of disciplines have proven to be very effective practitioners of family psychoeducation, including social workers, psychiatrists, case managers, nurses, occupational therapists and even some expert family members.

How can the PMHA assure that agencies will faithfully adhere to FPE principles?

The implementation resource kit includes a fidelity measure that assesses how closely the program implementation follows the approaches that have achieved results in the studies cited in the review. This checks both the agency's and the practitioners' adherence to standards. How successful a program using an Evidence Based Practice, such as FPE, is in improving outcomes depends, in part, on how closely the program follows the EBP model. Programs that only partially adopt the model or that are allowed to "drift" back into old ways of providing care may not produce the beneficial outcomes associated with FPE. This will be especially true if agencies and their practitioners view and interact with the family in ways that imply that the family is at fault.

What are the costs?

For the services

The direct financial costs of providing FPE is about $350 per year, per consumer in staff time for an ongoing multifamily group when using a master's level practitioner (based on East Coast salary levels). The ongoing multifamily group sessions require about one hour of staff effort per month per consumer, after the initial engagement and education sessions. Start-up costs are higher due to learning time and effort, initial single family sessions and the educational workshop. Each subsequent multifamily group requires less effort, as the learning curve flattens. Single-family format is roughly twice the cost per consumer.

To introduce the program

The initial implementation costs are about $250 per practitioner for staff recruitment, preparation, and associated costs for training.

Other agency costs include agency administration time, and staff time while participating in skills training, supervision and consultation activities.

What do people say about FPE?

"The (consumer) is much better—more active, more aware of his illness and [he exerts] more control over recognizing prodromal symptoms and getting help early on." ---L.B., FPE practitioner

"The experience of this group has shown us again and again the truth of the old cliche, that 'we are not alone'."

---John and Susan, parents of a daughter who has mental illness

The rewards of implementing these groups include "watching the families become stronger, more skilled, 'lighter'; watching people with schizophrenia improve in functioning."

---An Acadia Hospital administrator

Sample Medicaid Reimbursement Regulations and Code: Proposed Descriptors of Family Psychoeducation

The following language has been used to establish a special case-rate reimbursement methodology in the State of Maine.

Eligible Recipients

Those Medicaid recipients who are eligible to receive family psychoeducation include general and specific requirements as defined and elaborated in Sections 17.02-1,2 and 3. Persons meeting all other requirements but who are under the age of 18 will also be included as eligible.

Staffing

The practitioners eligible to provide family psychoeducation under Medicaid reimbursement include mental health professionals as defined in Chapter II, Section 17.09-1 and designated community support providers as defined in 17.09-2.

Covered services

Covered services include family psychoeducation provided in multifamily groups and in single family sessions. Covered services include family psychoeducation as defined under program elements provided to caretaking relatives and/or non-related caretaking persons, as well as to the eligible person. Covered services may be provided to the participating persons with or without the eligible person being present, if all other program requirements and elements are being provided.

Program elements of the covered services include:

Engagement sessions, usually involving caretakers and eligible Medicaid recipients, who may meet separately or together, depending on clinical condition and other considerations, to be determined by the eligible provider.

These sessions focus on:

- exploring precipitants of previous acute episodes of illness
- review of prodromal signs and symptoms
- reactions of the family in supporting family members with an illness
- coping strategies and strengths that have been successful
- social supports in the communities
- grief and mourning in relation to the illness and a contract for treatment and the development of a treatment plan

There may be three or more engagement sessions, as early in the course of an episode or illness as possible.

Educational workshops, involving caretaking relatives and, at the determination of the practitioners leading the workshop, eligible Medicaid recipients.

These workshops offer extensive information about the biological, psychological, and social aspects of mental illness, the nature, effects and side effects of psychiatric treatments, what families can do to facilitate recovery and prevention of relapse and guidelines for management of mental illnesses.

Ongoing supportive and problem solving sessions occur in a multifamily or single family format, usually with the eligible Medicaid recipient present.

These sessions follow an empirically tested format and focus on solving problems that interfere with treatment, illness and symptom management, and coping skills. Case management may also be accomplished during these sessions. They are usually biweekly, and become monthly after stability has been achieved. They continue for at least one year and two years is indicated for consumers who experience schizophrenic disorders.